Patient Name	Date of Birth	Patient ID

Today's Date:

OB/GYN Health History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)	Not Current
		___ / ___	
		___ / ___	
		___ / ___	
		___ / ___	

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Past Medical History

Check all diseases and conditions that apply.

- ☐ Abuse / Domestic Violence
- ☐ Acne
- ☐ ADHD
- ☐ Allergies (environmental/food)
- ☐ Genitourinary Disease
- ☐ HIV or AIDS
- ☐ Headaches
- ☐ Hematologic Disease

- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bi-Polar
- ☐ Breast Cancer
- ☐ Breast Disease
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Colon Polyp
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Dermatologic Disorder
- ☐ Diabetes Mellitus
- ☐ Diverticulitis
- ☐ Ear or Hearing Disorder
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Endocrine Disorder
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hepatic / Liver Disease
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBS
- ☐ Immunologic Disorder
- ☐ Kidney Stones
- ☐ Menopause
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Musculoskeletal Disease
- ☐ Neurologic Disorder
- ☐ Obesity
- ☐ Osteoporosis/Osteopenia
- ☐ Ovarian Cancer
- ☐ Psychiatric Illness
- ☐ Pulmonary / Lung Disease
- ☐ Renal / Kidney Disease
- ☐ Seizures / Epilepsy
- ☐ Sleep Apnea
- ☐ Substance Abuse/Dependence
- ☐ Thrombophilias
- ☐ Thyroid Disease
- ☐ Urologic Disorder

- [ ] Gastrointestinal Disease
- [ ] Genetic / Hereditary Disorder
- [ ] Vision / Eye Disorder
- [ ] Vitamin D Deficiency

Past Surgical History

Check all surgeries that apply.

- [ ] Appendectomy
- [ ] Back / Spine Surgery
- [ ] Breast Biopsy
- [ ] Breast Surgery
- [ ] Breast surgery - augmentation
- [ ] Breast Surgery - Lumpectomy
- [ ] Caesarean Section
- [ ] Cardiac - Angioplasty
- [ ] Cardiac - Catheterization
- [ ] Cardiac - Coronary Artery Bypass Graft
- [ ] Cardiac - Coronary Artery Stent
- [ ] Cardiac Surgery
- [ ] Cholecystectomy (Gallbladder)
- [ ] Cryosurgery
- [ ] Dermatologic Surgery
- [ ] Dilation and Curettage
- [ ] Ectopic Pregnancy
- [ ] Endometrial Ablation
- [ ] Gastrointestinal / Colon Surgery
- [ ] Gastrointestinal Bypass Surgery
- [ ] Gastrointestinal Surgery
- [ ] Laparoscopy
- [ ] Neurosurgery
- [ ] Laparotomy
- [ ] Maxillofacial Surgery
- [ ] Oncologic / Cancer Surgery
- [ ] Oophorectomy (ovary removal)
- [ ] Ophthalmologic Surgery
- [ ] Ophthalmology - Cataract Surgery
- [ ] Oral / Dental Surgery
- [ ] Orthopedic - Arthroscopic Surgery
- [ ] Orthopedic - Hip Replacement
- [ ] Orthopedic - Knee Replacement
- [ ] Orthopedic Surgery
- [ ] Otolaryngic (ENT) Surgery
- [ ] Ovarian Cystectomy
- [ ] Plastic / Reconstructive Surgery
- [ ] Pulmonary / Lung Surgery
- [ ] Splenectomy
- [ ] Thoracic / Chest Surgery
- [ ] Thyroid Surgery
- [ ] Tonsillectomy

- ☐ Genitourinary Surgery
- ☐ Hysterectomy (ovaries remain)
- ☐ Hysterectomy with Oopherectomy (ovaries removed)
- ☐ Hysteroscopy
- ☐ Inguinal Hernia
- ☐ LEEP
- ☐ Tubal Ligation
- ☐ Two unilateral mastectomies
- ☐ Urologic Surgery
- ☐ Vascular Surgery
- ☐ Vasectomy

Gynecology history

1. Date of LMP

   ____ / _____

2. Frequency of Cycle (Q days) _____

3. Duration of Flow (days) _____

4. Flow (Circle one)

   Light Moderate Heavy

5. Menses Monthly (Circle one)

   Yes No

6. Menstrual Cramps (Circle one)

   mild moderate severe

7. Premenstrual Syndrome (Circle one)

   Yes No

8. Date of Last Pap Smear

   ____ / _____

9. Date of HPV testing

   ____ / _____

10. HPV testing results (Circle one)

    Positive Negative

11. Abnormal Pap (Circle one)

    Yes No

12. Abnormal Pap Smear result (Circle one)

ASC-US ASC-H LSIL HSIL

AGUS

13. Any Treatment for Abnormal Pap? (Circle one)

Yes No

14. Colposcopy

____ / _____

15. Age at Menarche _____

16. If Post Menopausal, Age at Menopause _____

17. HPV Vaccine (Circle one)

Yes No

18. Sexual Orientation (Circle one)

Heterosexual Homosexual Bisexual Asexual

19. Number of Lifetime Sexual Partners _____

20. Sexually Active? (Circle one)

Yes No

21. Sexual Problems? (Circle one)

Yes No

22. STIs/STDs (Circle one)

Yes No

23. Current Birth Control Method (Circle one)

None	BCPs	Sterilization	Tubal Ligation
IUD	Condoms	Partner Vasectomy	Unknown
Depo-Provera	Vaginal Ring	Hysterectomy	Abstinence
Diaphragm	Seeking Pregnancy	Implant	Patch
Multiple Methods	Menopause	Spermicide	Pregnant
Withdrawal	Fertility Awareness Method	Ablation	Fertility Issues
Breastfeeding/LAM	Emergency Contraception	Sponge	Cervical Cap

Other N/A

24. Desired Birth Control Method (Circle one)

BCPs	Sterilization	IUD	Condoms
Hormonal Injection	Vaginal Ring	Abstinence	Diaphragm
Seeking Pregnancy	Implant	Patch	Multiple Methods
Spermicide	Fertility Awareness Method	Breastfeeding/LAM	Sponge
Cervical Cap	Partner Vasectomy	Hysterectomy	Ablation
Emergency Contraception	None	Unknown	Withdrawal
Other	N/A		

25. Date of Last Mammogram

____ / _____

26. Most Recent Mammogram

____ / _____

27. Mammogram Result (Circle one)

Normal Abnormal

28. Most Recent Bone Density

____ / _____

29. Date of Last Colonoscopy

____ / _____

30. Endometriosis (Circle one)

Yes No

31. Fibroids (Circle one)

Yes No

32. Infertility (Circle one)

Yes No

33. Ovarian Cyst (Circle one)

Yes No

34. PCOS (Circle one)

Yes No

Family History

Check all diseases and conditions that apply.

- ☐ Addiction — Family member(s): _____
- ☐ Allergy — Family member(s): _____
- ☐ Anemia — Family member(s): _____
- ☐ Anxiety disorder — Family member(s): _____
- ☐ Arthritis — Family member(s): _____
- ☐ Asthma — Family member(s): _____
- ☐ Blood coagulation disorder — Family member(s): _____
- ☐ Cerebrovascular accident — Family member(s): _____
- ☐ Chronic obstructive lung disease — Family member(s): _____
- ☐ Coronary arteriosclerosis — Family member(s): _____
- ☐ Cystic fibrosis — Family member(s): _____
- ☐ Depressive disorder — Family member(s): _____
- ☐ Developmental disorder — Family member(s): _____
- ☐ Diabetes mellitus — Family member(s): _____
- ☐ Disease of liver — Family member(s): _____
- ☐ Disorder of cardiovascular system — Family member(s): _____
- ☐ Disorder of endocrine system — Family member(s): _____
- ☐ Disorder of gastrointestinal tract — Family member(s): _____
- ☐ Disorder of lung — Family member(s): _____
- ☐ Disorder of nervous system — Family member(s): _____
- ☐ Disorder of respiratory system — Family member(s): _____
- ☐ Disorder of the genitourinary system — Family member(s): _____

☐ Disorder of thyroid gland	Family member(s): _____
☐ Emphysema	Family member(s): _____
☐ Endometrial carcinoma	Family member(s): _____
☐ Headache	Family member(s): _____
☐ Heart disease	Family member(s): _____
☐ Heart failure	Family member(s): _____
☐ High risk pregnancy	Family member(s): _____
☐ Hypercholesterolemia	Family member(s): _____
☐ Hypertensive disorder	Family member(s): _____
☐ Hypertriglyceridemia	Family member(s): _____
☐ Immunodeficiency disorder	Family member(s): _____
☐ Kidney disease	Family member(s): _____
☐ Malignant neoplasm of uterus	Family member(s): _____
☐ Malignant neoplastic disease	Family member(s): _____
☐ Malignant tumor of breast	Family member(s): _____
☐ Malignant tumor of cervix	Family member(s): _____
☐ Malignant tumor of colon	Family member(s): _____
☐ Malignant tumor of lung	Family member(s): _____
☐ Malignant tumor of ovary	Family member(s): _____
☐ Malignant tumor of stomach	Family member(s): _____
☐ Mental disorder	Family member(s): _____
☐ Migraine	Family member(s): _____
☐ Multiple sclerosis	Family member(s): _____
☐ Myocardial infarction	Family member(s): _____
☐ Obesity	Family member(s): _____

☐ Osteoporosis Family member(s): _____

☐ Rheumatoid arthritis Family member(s): _____

☐ Seizure Family member(s): _____

☐ Sudden cardiac death Family member(s): _____

☐ Tuberculosis Family member(s): _____

Social History

1. Do you have a Advance Directives to guide your healthcare in the event you are unable to make decisions? (Circle one)

Yes No

2. Marital status (Circle one)

Unknown Married Single Divorced

Separated Widowed Domestic Partner

3. Do you feel safe in your current relationship? (Circle one)

Yes No

4. Sexual orientation? (Circle one)

Lesbian or gay or homosexual Straight or heterosexual Bisexual Something else

Don't know Choose not to disclose

5. Number of children (Circle one)

0 1 2 3

4 5 6 7

8 9+

6. Are you working (Circle one)

Yes Retired looking for work Disabled

Stopped due to pain

7. Occupation _____

8. On average, how many days per week do you engage in moderate to strenuous EXERCISE (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a

light or heavy sweat)? _____

9. On those days, how many minutes, on average, do you engage in EXERCISE at this level?

_____

10. How often do you have a DRINK containing ALCOHOL? (Circle one)

Never | Monthly or less | 2-4 times a month | 2-3 times a week

4 or more times a week

11. How often do you have six or more DRINKS on one occasion? (Circle one)

Never | Less than monthly | Monthly | Weekly

Daily or almost daily

12. How many standard DRINKS containing alcohol do you have on a typical day? (Circle one)

1 or 2 | 3 or 4 | 5 or 6 | 7 to 9

10 or more

13. Illicit drugs _____

14. Have you recently (within the last 12 weeks, or during a current pregnancy) traveled to or lived in a Zika-affected area? (Circle one)

Yes No

15. Do you have symptoms associated with Zika virus (fever, rash, joint pain, or conjunctivitis)? (Circle one)

Yes No

16. Are you currently sexually active with anyone who has traveled (within the last 12 weeks) to a Zika-affected area? (Circle one)

Yes No

17. Are you planning to conceive with someone who has traveled (within the last 12 weeks) to a Zika-affected area? (Circle one)

Yes No

18. Have you had sexual relations with anyone who has been positively diagnosed with Zika virus within the last 6 months? (Circle one)

Yes No

19. Is blood transfusion acceptable in an emergency? (Circle one)

Yes No

20. Chewing tobacco (Circle one)

none 1/day 2-4/day 5+/day

21. PCP completion date

____ / _____

22. Smoking - How much? (Circle one)

None 1 PPW 2 PPW 1/4 PPD

1/2 PPD 1 PPD 1 1/2 PPD 2 PPD

3+ PPD

23. Tobacco Smoking Status (Circle one)

Never smoker Former smoker Current every day smoker Current some day smoker

Smoker - current status unknown Unknown if ever smoked

24. Tobacco-years of use _____